Commonwealth of Kentucky
Personnel Cabinet
Department for Employee Insurance
Enrollment Information Branch
(502)564-1205
(502)564-1085 Fax

2008 DEPENDENT ADD FORM

Give this form to your Insurance Coordinator

This form must be used for any qualifying event (QE) that allows you to add dependents to your plan. *Complete an Enrollment Application for election changes such as option changes, new coverage, new waiver or to begin a cross-reference plan.*

Applicant's SSN | Retiree's SSN (if applicable) | Company Number

Print Name (First, MI, Last) _____

To be eligible to add a dependent to your health insurance plan, you must certify that you have experienced the QE as listed here. The QEs listed on this form are the only events that allow you to ADD dependents to your plan. To be considered an eligible dependent, your dependent MUST meet the eligibility requirements as set forth in the KEHP Health Insurance Handbook. Please check one of the conditions below:

- ☐ Your Legal Spouse; or
- ☐ Your unmarried child, stepchild, adopted/placed child or foster child that will remain under age 24 in the current plan year, and depends on the employee for more than 50% of his/her support and maintenance and resides in the household in a parent-child relationship. (**Exception to the residency requirement:** *Court Orders and Administrativeorders to provide health coverage for the child.*)
- ☐ Your grandchild who meets the requirements listed above and for whom you have a court order or administrative order.

NOTE: EFFECTIVE DATE FOR COVERAGE WILL BE ON/AFTER THE EVENT HAS OCCURRED AND/OR 1ST DAY OF THE FOLLOWING MONTH FROM MEMBER'S SIGNATURE DATE ON THE ADD FORM, *except for Birth, Birth plus, Adoption / Placement and placement for Adoption plus, which are effective on the date of the event; and National Medical Support Notices which are effective on the 1st day of the month after notice date.*

Qualifying Events: (Check one)

- ☐ Birth newborn only (60 days)
- ☐ Birth plus other dependents (30 days)
- ☐ Adoption*/ Placement for Adoption* (60 days)
- ☐ Adoption*/ Placement for Adoption* plus other dependents (30 days)
- ☐ Legal guardianship*, Administrative Order* or court order* pertaining to health insurance+
- ☐ Marriage
- ☐ Sp/Retiree has different Open Enrollment period*+
- ☐ Sp/Dep loses other coverage*
- ☐ Sp/Dep loses governmental group coverage*
- ☐ Dependent Care FSA significant cost increase
- ☐ Unmarried dependent re-establishes eligibility* (member must supply information on reason to re-establish eligibility)
- ☐ Other_____

Qualifying Event Date (mm/dd/yy): _____

Note: SP = Spouse DEP = Dependent

**Supporting documentation required*

+Refer to QE chart at www.KEHP.ky.gov for rules/effective dates

PRINT the following information for each dependent to be added:

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth	Rel.Code **
		M F		
		M F		
		M F		
		M F		

****** Rel. Code: SP = Spouse / CH = Child / CO = Court Ordered Dependent / DD = Disabled Dependent

My signature below certifies that I understand the statements on this form and that all the information provided by me is true and complete to the best of my knowledge. I understand that any person who knowingly and with intent to defraud any insurance company or other person, files this form containing any materially false information or conceals, with the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I understand that any material misrepresentation or material omission contained herein may be used to void this contract.

Applicant Signature | Date | Insurance Coordinator Signature | Date

Signatures are required below if changes to an existing cross-reference plan are being requested

Spouse Signature | Date | Spouse Insurance Coordinator Signature | Date